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November 30, 2016

VIA ELECTRONIC FILING

The Honorable Thomas Wheeler
Chairman

The Honorable Mignon Clyburn
Commissioner

The Honorable Jessica Rosenworcel
Commissioner

The Honorable Ajit Pai
Commissioner

The Honorable Michael O'Rielly
Commissioner

Federal Communications Commission
445 12th Street, S.W.
Washington, DC 20554

Re: Request for Short-Term Emergency Relief
Rural Health Care Program $400 Million Funding Cap
WC Docket No. 02-60

Chairman and Commissioners:

Participants in the Rural Health Care ("RHC") Program face great uncertainty as funding requests approach the $400 million cap.[1] Hitting the cap could occur this year and poses complex administrative challenges for individual health care providers ("HCPs"), consortia of HCPs, service providers, and the program administrator (USAC). More important, hitting the cap could mean flash cuts or reductions in support for many participants in the program with possible service interruptions to broadband connectivity used for healthcare. For these and other reasons, we urge the Commission to take immediate steps to provide interim relief from the RHC Program funding cap. The steps we propose will give program participants needed time to adjust to cap realities, will avoid potential service interruptions, and will give the Commission time to fully consider the

[1] *See Wireline Competition Bureau Provides a Filing Window Period Schedule for Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, WC Docket 02-60, Public Notice, DA 16-979, at 2 (Wireline Comp. Bur.; rel. Aug. 26, 2016) (*Funding Window PN*) (noting "historic high of $377.64 million" in funding requests).

effects hitting the cap will have on rural HCPs that depend on the RHC Program more than ever before.

Specifically, we ask the Commission to direct USAC to reallocate unused RHC funds that were committed in previous funding years to current applicants if the funding cap is reached in this funding year. Because such funds have already been collected by USAC, this temporary step will not cause any increase in the universal service fund ("USF") contribution factor. A nearly identical mechanism has been in place in the Schools and Libraries program since 2002.[2] We seek this temporary relief for funding years 2016 and 2017 only.

Background

Congress established the RHC program in 1996 to ensure rural HCPs "an affordable rate for the services necessary for the provision of telemedicine and instruction,"[3] and all HCPs access to "advanced services"[4] – what we now call broadband. Twenty years later, the RHC program is the smallest of the four universal service programs, representing about 2% of total USF disbursements in 2014 (the most recent data available).[5] Yet the program is growing – some might say thriving – as HCPs adopt electronic health records and rely increasingly on telemedicine to provide access to basic and specialty care to rural communities. These changes are being driven by technology, economic realities, and federal policies.[6]

The Commission set the $400 million RHC Program funding cap in 1997 – but disbursements in the program's first year (1998) were less than $4 million. For many years the RHC Program grew slowly but steadily, with disbursements reaching $40 million in 2005, $86

[2] *See* 47 C.F.R. § 54.507(a)(5) ("On an annual basis . . . all funds that are collected and that are unused from prior years shall be available for use in the next full funding year of the schools and libraries mechanism in accordance with the public interest and notwithstanding the annual cap as described in this paragraph (a)."); § 54.507(a)(6) ("All funds collected that are unused shall be carried forward into subsequent funding years for use in the schools and libraries support mechanism in accordance with the public interest and notwithstanding the annual cap."); *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, First Report and Order, 17 FCC Rcd 11521 (2002) (*E-rate First Report and Order*).

[3] *See Funding Window PN*, at 1 (citing S. Conf. Rep. No. 104-230 (1996) and 47 U.S.C. § 254(b)(3), (h)(1)(A)).

[4] *See* 47 U.S.C. § 254(b)(6), (h)(2)(A).

[5] *See* 2015 Universal Service Monitoring Report, CC Docket 96-45, *et al.*, at Table 1.10 (rel. Dec. 22, 2015) (reporting $193 million in RHC disbursements for calendar year 2014 out of $7.85 billion total).

[6] "The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111–5) was enacted on February 17, 2009. Title IV of Division B of ARRA amends Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs). These incentive payments are part of a broader effort under the HITECH Act to accelerate the adoption of HIT and utilization of qualified EHRs." *See* Center for Medicare & Medicaid Services website, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ (last visited Nov. 11, 2016).

million in 2010, and $193 million in 2014. This summer, annual requests for RHC funding reached $377 million – a sharper increase than in previous years – causing the Wireline Competition Bureau to implement filing windows for the first time.[7] While filing windows ensure fairness by requiring equal treatment for all funding requests submitted in a window, HCPs now face the uncertainty of having their requested support amounts reduced by an unknown factor, or possibly having their support requests denied.

Based on discussions with program participants, we believe increased reliance by HCPs on information technology and broadband are playing a substantial role in the increased demand for program funds. Indeed, the RHC Program, by facilitating broadband adoption by HCPs – particularly rural HCPs – appears to be functioning precisely how Congress intended.

In addition to higher-than-expected growth in demand for RHC funding, Congress this summer added a new type of HCP eligible to receive RHC Program funding: "skilled nursing facilities" ("SNF").[8] Unknown at this time are the potential number of eligible SNFs that exist nationwide. Ironically, if the $400 million cap is hit this year, it is possible that SNFs seeking RHC Program support for the first time will receive little to no program funding.[9]

Finally, in December 2015, the Schools, Health & Libraries Broadband ("SHLB") Coalition, along with six statewide and regional telehealth networks, filed a petition for rulemaking seeking further modernization of the RHC program.[10] Among many suggestions to modernize and make the RHC program more effective, SHLB petitioners proposed recalibrating the $400 million funding cap based on established program objectives and a comprehensive count of potentially eligible entities. Petitioners also specifically proposed the Commission establish mechanisms to provide short-term relief in the event that demand for funding from the Rural Health Care Program

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[7] *See* n.1, *supra*.

[8] *See* Frank R. Lautenberg Chemical Safety Act for the 21st Century Act, Title II – Rural Healthcare Connectivity, Pub. L. No. 114-182 (2016) (*Lautenberg Act*), signed into law by President Obama on June 22, 2016. *See also* 47 U.S.C. § 254(b)(7)(B)(vii) ("[The term 'health care provider' means] skilled nursing facilities (as defined in section 395i–3(a) of title 42)").

[9] *See Funding Window PN* at 4 (noting SNFs can participate in the program no sooner than funding window #3 which starts February 1, 2017). While Congress provided that adding SNFs "shall [not] be construed to affect the aggregate annual [RHC] cap" – see *Lautenberg Act* at section 202(b) – this language does not restrict the FCC from taking action related to the cap.

[10] *See* http://apps.fcc.gov/ecfs/comment/view?id=60001324308 ("SHLB Petition"). Petitioners in addition to the SHLB Coalition were as follows: New England Telehealth Consortium (Maine, New Hampshire, and Vermont), California Telehealth Network, Health Information Exchange of Montana, Utah Telehealth Network, Colorado Telehealth Network, and Southwest Telehealth Access Grid (New Mexico and Arizona). The Wireline Competition Bureau sought and received public comments on the *SHLB Petition* in January 2016. *See Wireline Competition Bureau Invites Comment on Petition for Rulemaking Filed by Schools, Health, & Libraries Broadband Coalition, California Telehealth Network, New England Telehealth Consortium, Health Information Exchange Of Montana, Utah Telehealth Network, Colorado Telehealth Network, And Southwest Telehealth Access Grid Seeking Further Modernization Of The Rural Health Care Program*, WC Docket No. 02-60, Public Notice, DA 15-1424 (rel. Dec. 15, 2015). The *SHLB Petition* remains pending.

exceeds the $400 million cap.[11] At the time the *SHLB Petition* was filed, projections based on historical demand did not suggest the RHC program was in danger of hitting the cap in funding year 2016.[12]

Immediate Impacts of Hitting the RHC Funding Cap

Operation of the RHC funding cap this year could create havoc in the RHC Program. For example, it is not clear whether USAC has sufficient staff or systems to handle complex cap mechanics and the increased volume of program activity:

- USAC is still processing the record number of requests for funding year 2015 (which ended June 30, 2016). With the November 30 filing window, USAC will have a record number of requests to process for the current funding year – 7 months earlier than has historically been the case. USAC will have to finish 2015 requests, process 2016 requests, and quickly report total funding requests in order to determine whether funding is available for a third funding window.

- If the cap is hit in 2016, USAC's systems must be capable of automatically calculating pro-rated support as current cap rules require. It is unclear whether these systems have been tested. Consortia funding applications in particular are already quite complex – with current USAC systems not always able to handle complex cost allocation requirements. We have been unable to determine how these applications will be affected by pro-rating support on top of an already complex consortium cost allocation processes.

If USAC is unable to smoothly handle these and other unanticipated challenges, this will have dramatic effects on all program participants. But even if USAC functions smoothly throughout, there will be significant direct effects on HCPs if funding requests are unexpectedly reduced (pro-rated) or denied entirely. Such flash cuts or reductions in funding:

- Will stress an already stressed rural health care system and further undermine the economic viability of struggling rural critical access hospitals.[13]

[11] *See SHLB Petition* at 30-33.

[12] The few commenters opposing petitioners' interim cap relief proposals did so in part based on assertions that expected low funding demand meant that such relief was not needed. *See* USTA Comments at 11 ("[RHC] funding disbursements have never come close to exceeding the cap. As such, no need exists for the Commission to adopt measures for [a short term cap relief] mechanism"); NTCA Comments at 15 ("[B]ased on real-world experience [*i.e.*, current RHC demand projections], a provision for short-term funding relief is not necessary.").

[13] *See* North Carolina Rural Health Research Program, University of North Carolina, *78 Rural Hospital Closures: January 2010 – Present*, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited Nov. 17, 2016)

- Could reduce or interrupt broadband services used to provide healthcare and thus impact patient care.

- Could impact health IT planning at HCPs. Planned-for circuits may no longer be affordable and implementation of new programs may be postponed.

- Service providers often provision HCP circuits in advance of USAC funding decisions. If a broadband circuit is provisioned and in use for several months, and then USAC reduces or denies a funding request for that circuit due to the cap, an HCP will face substantial disruption if it cannot afford the full undiscounted cost of that circuit.

HCP consortia face the same issues as individual HCPs but also face further challenges. Uncertain levels of RHC support will make it more difficult for consortia to attract and retain members.

Service providers will also face unanticipated problems if the cap is hit. The Commission has not made clear whether service providers are expected to forgive the cost of expensive circuits that are not fully funded because of the cap (assuming they are willing and able to). The resulting uncertainty will only cause service providers to avoid the RHC program, thereby decreasing the number of potential bidders and raising program costs for individual connections, as service providers factor the increased risk of reduced payment or non-payment. These are just a few of the issues that the FCC will face if the RHC funding cap is reached.

How Much Potential Undisbursed RHC Funding Is There?

As the Commission has explained, unused funding in the E-rate program is "the result of normal program operation."[14] The same is true with the RHC Program which operates using the same process of funding commitments which are often not fully expended by applicants. In its 2013 Annual Report, USAC reported the following cumulative information regarding RHC program disbursements and commitments:[15]

Calendar Years	Committed	Disbursed	Undisbursed	Rate
1998-2013	$702,293,000	$653,029,000	$49,264,000	7%

Thus, from the RHC program's inception through the end of calendar year 2013, $49 million of RHC funding was authorized but not disbursed. By extrapolating the 7% rate of

[14] *See E-rate First Report and Order* at ¶ 21; *Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan for our Future*, CC Docket No. 02-6, GN Docket No. 09-51, Order, 25 FCC Rcd 18762, ¶ 34 fn.106 (2010) ("There are a variety of reasons why funds that are committed are ultimately not distributed. For example, [applicants] are able to find cost savings through efficient resource use, and thus ask for less in reimbursement than the amount originally anticipated and committed.").

[15] *See* USAC 2013 Annual Report (Revised) at 41, http://usac.org/_res/documents/about/pdf/annual-reports/usac-annual-report-2013-revised.pdf.

undisbursed funds over this 15-year period to subsequent years[16] we can estimate undisbursed RHC funds potentially available for rollover:

Funding Year	**Authorized**[17]	**Potential Undisbursed** (assuming 7% rate)
2013	$157,650,000	$11,058,731
2014	$192,000,000	$13,468,293
2015	$278,960,000	$19,568,308
	TOTAL	**$44,095,332**

The rollover process for unused funding has worked smoothly in the E-rate program for many years. We recognize that the Commission would have to adopt rule changes to permanently implement a similar rollover mechanism in the RHC Program. In that regard, the *SHLB Petition*, which remains open for public comment in the RHC docket, proposes a rulemaking proceeding to specifically consider (among other things) adoption of rules providing for rollover of unused funding.[18]

In the meantime, we believe this matter is sufficiently urgent that temporary steps should be taken regardless of whether a full rulemaking in response to the *SHLB Petition* is initiated.[19] Moreover, given the clear precedent in the E-rate program for rollover of unused funds, temporary action in the RHC program does not appear to present novel questions of fact, law, or policy. If there is no disagreement among the Commissioners, we encourage the Commission to direct the Wireline Competition Bureau or the Office of the Managing Director to address this matter expeditiously. Alternatively, we urge the Commission to act quickly as it did when enacting the bridge funding order which provided timely funding relief to pilot projects prior to implementation of the Healthcare Connect Fund.[20]

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[16] USAC reports historical disbursement data on a calendar year basis, while funding requests are reported on a funding year ("FY") basis. Funding years run from July 1 to June 30 of the next year, *e.g.*, FY 2013 ran from July 1, 2013 to June 30, 2014.

[17] *See* USAC 2015 Annual Report, at 41, https://usac.org/_res/documents/about/pdf/annual-reports/usac-annual-report-2015.pdf. USAC explains the difference between "authorized support" and "funding commitment" on page 41 at the link above. This distinction does not change the basic analysis presented here.

[18] *See* n.11, *supra*.

[19] *Cf. Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶ 713 (1997) (subsequent history omitted) ("We will consider the need to revise the [RHC] cap . . . if we find it necessary to ensure the sufficiency of the fund or to respond to requests from interested parties for expedited review.").

[20] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 27 FCC Rcd 7907 (rel. Jul. 6, 2012); *Wireline Competition Bureau Seeks Comment on Funding Pilot Program Participants Transitioning Out Of The Rural Health Care Pilot Program In Funding Year 2012*, WC Docket 02-60, DA 12-273 (rel. Feb. 27, 2012).

Respectfully submitted,

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On behalf of:
SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION
CALIFORNIA TELEHEALTH NETWORK
NEW ENGLAND TELEHEALTH CONSORTIUM
HEALTH INFORMATION EXCHANGE OF MONTANA
UTAH TELEHEALTH NETWORK
OCHIN
TEXAS HEALTH INFORMATION NETWORK COLLABORATIVE
KENTUCKY TELEHEALTH CONSORTIUM
COLORADO TELEHEALTH NETWORK
SOUTHWEST TELEHEALTH ACCESS GRID
PALMETTO STATE PROVIDERS NETWORK